

Patient Information Form

First Name: _____ Last Name: _____ Middle Name: _____

Preferred Name: _____

Date of Birth (*required*): _____ Gender: _____

Address: _____ Unit #: _____ City: _____

State: _____ ZIP: _____ Email: _____

Phone *Appointment reminders will be send to 1st preference*

1. Home Work Cell (_____) _____ 2. Home Work Cell (_____) _____

*Confidential voicemails OK? Yes No

*Confidential voicemails OK? Yes No

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Are you currently employed? No Yes Employee/Address: _____

Insurance Information (We will need a copy of your insurance card)

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber _____ Date of Birth (*required*): _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber _____ Date of Birth (*required*): _____

Auto Accident Workers Compensation Date of accident or injury: _____ Claim #: _____

Parent/Guardian/Information

To be filled out if patient is a minor, or if someone other than the patient is medically and financially responsible for the patient.

Mother's Name (*minors only*): _____

Legal Guardian? Yes No Date of Birth (*required*): _____

Father's Name (*minors only*): _____

Legal Guardian? Yes No Date of Birth (*required*): _____

Other Legal Guardian Name: _____

Relationship to Patient: _____ Date of Birth (*required*): _____

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the Informed Consent for Treatment form.

Patient Signature (*18 and older*): _____ Date _____

Parent/Guardian Signature : _____ Date _____

Patient Profile

Medical History continued...

| Condition | SELF | RELATIVE | Condition | SELF | RELATIVE |
|-------------------|------|----------|--------------------|------|----------|
| Clotting Disorder | | | Sickle Cell Anemia | | |
| COPD | | | Stroke | | |
| Depression | | | Substance Abuse | | |
| Diabetes | | | Thyroid Disease | | |
| Emphysema | | | Tuberculosis | | |
| GERD | | | Ulcers | | |
| Glaucoma | | | Other | | |
| Heart Attack | | | Other | | |
| Heart Murmur | | | Other | | |

Please list any surgeries or hospital stays you have had and their approximate date/year: *Type of surgery/reason for hospitalization:*

Date:

Social History

Do you use any of the following substances regularly?

Coffee/Black Tea/Cola
 Alcohol
 Recreational Drugs
 Tobacco- Current/Past

If Current or Past Tobacco Us Packs Per Day: _____ How Long: _____ Quit: _____

Please mark those that apply: Single Married Significant Other Divorced Other: _____

Do you have children? Yes No If YES, what are their ages: _____

Do you follow any particular diet restrictions? Yes No If Yes, please describe:

Do you exercise regularly? Yes No If YES, please describe type of exercise and how often:

CASCADE HEALTH CLINIC, LLC
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Sarah F Sadler, ND, and her covering physicians, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, and laboratory, x-ray.

Minor office Procedures: e.g., dressing a wound, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections. **Botanical Medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.

Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Pharmaceuticals: e.g., antibiotics, hormones, and other pharmaceutical medications
& Other Naturopathic Modalities

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from infections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Payment Policy: Payment is due at the time of service. If your insurance does not cover your visit, you are required to pay for any due bills before being seen. Cancellations must be made at least 24 hours in advance or patient will be billed for full amount of appointment. I further authorize my signature to remain on file for insurance claim

Signature on File: I authorize the release of any medical or other information necessary to process any insurance claims. I also request payment of government benefits to the party who accepts assignment on the insurance claim. I authorize payment of medical benefits to the undersigned physician in the insurance claims. I understand my signature will be on file with Cascade Health Clinic, LLC and used for any insurance claims filed on my behalf.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Cascade Health Clinic, LLC, or any of its personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my practitioner will answer any questions I have to the best of their ability.

Notice of Privacy Practices -- Acknowledgment

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee, if any. I may also ask to correct that record. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research or educational purposes, and that my identity will be protected and kept confidential. (Our **Notice of Privacy Practices** is available to you and describes in more detail how your health information may be used and disclosed, and how you can access your information.) By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Date

Signature of Patient (Guardian if child)

Original: Chart

Copy: Patient (if requested)

